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BEST ADVICE

Recovery-Oriented Mental Health and Addiction Care in the Patient's Medical Home

OCTOBER 2018

This guide is dedicated to the memory of Dr. Roger Bland, who exemplified patient-centred care and was committed to improving access to mental health care through the better integration of mental health and primary care services. As a clinician, researcher, teacher, academic leader, and policy maker he was a wise adviser to many individuals and organizations—including in the development of this guide. He appreciated the importance of the principles of recovery long before they were widely adopted.

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INTRODUCTION

Good mental health is associated with better physical health outcomes and is a key component of overall health and well-being.¹ Family physicians are one of the first points of contact with the health care system and play a critical role in providing primary care and care coordination to individuals experiencing a range of mental health and addiction (MH&A*) issues.

Family physicians in a Patient's Medical Home (PMH) model provide quality primary mental health care over a patient's lifespan, as a part of their continued commitment to patient-centred, comprehensive, and coordinated care. Making practices truly welcoming and equitable to people with MH&A issues takes the combined effort of the whole team, not just family physicians themselves. All team members have important roles to play. This guide summarizes how family physicians and their teams can work together to improve the quality of care provided to patients with MH&A issues. It covers how to:

- Understand the background of recovery-oriented practice in Canada
- Use strengths-based language when communicating with patients
- Facilitate patient choice and shared decision making in your practice
- Enhance your clinic's operations with practical changes including signage and processes
- Connect patients with community resources
- Address co-occurring MH&A issues and physical health problems by integrating screening, treatments, and supports

Readers of this guide will have a greater appreciation of how mental health manifests in family practice. By applying some of the suggestions in the areas of focus, they will be better able to care for people with MH&A issues.

PURPOSE OF THIS GUIDE

This document provides guidance for offering MH&A services using a recovery-oriented approach in the context of the PMH.

While applying to family physicians in many practice types, the recommendations are especially relevant for practices aligned with the PMH vision. The guide may also be relevant to other health care providers working collaboratively with family physicians in team-based practices. Practising in alignment with the PMH model—by focusing on continuous, comprehensive, and collaborative care, centred on the needs of the patient—can be a particularly effective way of providing care to people living with MH&A issues.

The [Patient's Medical Home](#) is the vision for the future of family practice in Canada. Created by the College of Family Physicians of Canada (CFPC), this vision calls for family practices that offer seamless care, centred on individual patients' needs, within their communities, throughout every stage of life, and that are integrated with other health services. Relationships between and among providers, patients, and families are central to the PMH. The PMH is the central hub for the timely provision and coordination of the comprehensive care needed for patients' physical and mental well-being.

*See the Note on language section for more information about this term.

NOTE ON LANGUAGE

There are many terms used to describe mental health, substance use, and addiction problems. For the purposes of this guide, we use the inclusive phrase “mental health and addiction (MH&A) issues,” which encompasses the following:

- Any issues related to mental health
- Mental disorders/illnesses
- Substance use disorders
- Addictive disorders

The [Guidelines for Recovery-Oriented Practice](#) were released by the Mental Health Commission of Canada (MHCC) in 2015. They are a comprehensive resource for health care professionals, policy makers, and the public that provide an overview of the concept of recovery-oriented practice. This concept has been championed by people with lived experience of MH&A issues and has been widely embraced as key to helping patients achieve better health outcomes and life satisfaction, and to improving mental health systems.²

BACKGROUND

Mental illness and addiction in Canada

- In 2012, 1.6 million people reported an unmet need for mental health care,³ and 7.5 million people in Canada were living with a mental health issue⁴
- It is estimated that about one in five Canadian youth are affected by a mental illness at any given time, and by age 40, half of all Canadians will have experienced a mental health issue⁵
- Mental illness costs the Canadian economy at least \$50 billion annually, via health care costs, lost productivity, and reductions in health-related quality of life⁶
- People living with serious mental illnesses are at greater risk of a range of chronic physical health problems. People living with chronic physical health conditions also experience some mental illnesses (e.g., depression and anxiety) at twice the rate of the general population.⁷
- Mental illness and addiction can lead to premature death. A mental illness can reduce a person’s life expectancy by between seven and 20 years. Those with serious mental illnesses are the most likely to experience a shortened lifespan.⁸



ROLE OF PRIMARY CARE IN MENTAL HEALTH

- Family physicians deliver up to two thirds of all mental health services^{9,10}
- Some family physicians are not comfortable or confident in their ability to provide care to patients experiencing MH&A issues^{11,12}
- Some patients with MH&A issues report experiencing barriers to accessing care for a variety of reasons; for example:
 - o People with serious mental illnesses (e.g., psychotic disorders or bipolar disorder) are less likely to have a primary care practitioner whom they see on a regular basis¹³
 - o One third of Canadians over the age of 15 with a mental illness reported that their care needs were not fully met by the health system¹⁴
 - o Some patients feel they can only address one health issue per doctor visit or are rushed through appointments, resulting in barriers to accessing mental health care¹⁵

Over the past two decades there have been many reports that the Canadian mental health care system needs to do more to improve access to MH&A care.^{16,17} Adopting the PMH model can help physicians provide additional comprehensive mental and physical health care within their current environment. In fact, some research demonstrates that patients who receive MH&A care in collaborative and integrated care settings (aligned with the PMH) experience improved health outcomes; for example, better physical health status and reductions in symptoms of depression, anxiety disorders, and risky drinking.^{18,19,20} Similarly, patients with a continuous and long-term relationship with their primary care physician report experiencing better quality care and better outcomes.^{21,15}

What is meant by recovery in mental health care

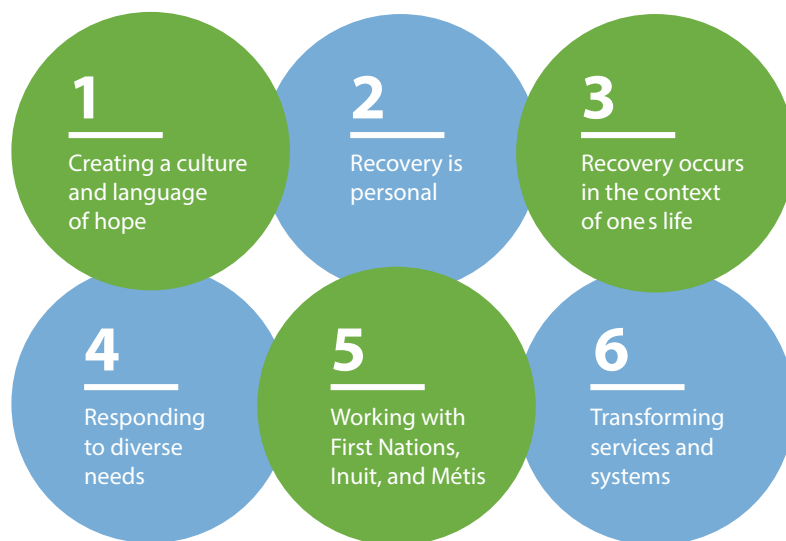
Helping patients reach optimal mental health is about more than reducing or managing symptoms. It is about supporting patients to live satisfying, hopeful, and contributing lives, even when there are ongoing limitations caused by MH&A issues.² This is the focus of recovery. While symptom reduction might be one component of a treatment plan, it may not be the only or most important goal. Although full remission of symptoms may be possible for some, for others the symptoms of a mental health issue may be chronic and require consistent management over their lifetime.²² Because of the long-term relationship that family physicians have with patients, they are a key care provider for all patients experiencing mental health issues.

Recovery is a personal and self-determined journey toward well-being, with every person having their own set of unique experiences and needs. Recovery journeys build on individual, family, cultural, and community strengths, and are supported by many types of services and treatments (Figure 1). While family physicians may not be able to address every aspect of a person's recovery, they play an integral role in diagnosing and treating both physical and mental health conditions, and can help foster hope, and facilitate choice and access to a range of appropriate treatments. People are more likely to achieve mental well-being if health care professionals help them understand and believe that recovery is possible.⁹

Pessimistic views about the likelihood of recovery can be viewed and experienced by patients as a source of stigma, which in turn becomes a barrier to accessing care and more broadly, a factor in poorer quality physical and mental health care.^{23,24} Employing recovery-oriented principles in your practice by engaging patients in open, respectful, and collaborative conversation can help overcome this barrier and improve the quality of care provided.

For an overview of the alignment between the recovery principles and the PMH vision, refer to Appendix A.

Figure 1. The six dimensions of recovery-oriented practice



Content adapted with permission from the Mental Health Commission of Canada.²⁵

RECOMMENDATIONS FOR BUILDING A RECOVERY-ORIENTED CARE PARTNERSHIP WITH PATIENTS LIVING WITH MH&A ISSUES

Use strengths-based language when communicating with patients

Using positive and hopeful language, and focusing on each patient's individual strengths, is central to providing recovery-oriented care to patients with MH&A issues.²⁶ By using strengths-based and optimistic language, you can combat stigma and create safe spaces where patients are comfortable discussing their goals. Table 1 and Appendix B share specific language tips.

Listening is an equally important element of recovery-oriented practice. When interacting with patients, it can help to mirror the language the individual uses to describe themselves (such as “mad” or “consumer survivor”), while also challenging self-stigma. This can reassure patients and demonstrate your commitment to listening and collaboration.

Focusing on appropriate use of language can help you develop stronger patient-provider relationships and overcome stigma. Efforts to use appropriate language can also be supported by using the principles described in the CFPC Best Advice guide *Health Literacy in the Patient's Medical Home*, including using plain and accessible language with patients.

Talking to patients about pharmacological treatments

Medications are often part of the evidence-based menu of treatment options available when developing personalized treatment plans. Patients may not realize that some psychotropic medications can have side effects that may impact their daily functioning. Some may have already considered which side effects they are willing to live with, and/or others that they do not consider acceptable. Engaging the patient honestly and openly about this treatment option includes sharing information about costs, timing, side effects, dosage, how it fits with other treatments, and exploring patient expectations, concerns, and preferences openly.

Table 1: How to use positive recovery-oriented language

Stigmatizing language	Positive language
<ul style="list-style-type: none"> ✗ DON'T label people: ✗ DON'T say "he/she is mentally ill" ✗ DON'T define the person by their struggle or distress ✗ DON'T equate the person's identity with a diagnosis <p>Very often there is no need to mention a diagnosis at all. However, it is sometimes helpful to use the phrase "a person diagnosed with" because it shifts responsibility for the diagnosis to the person making it, leaving the individual the freedom to accept it or not.</p>	<ul style="list-style-type: none"> ✓ DO use strengths-based, positive and supportive language, and put people first: ✓ DO say "a person living with a mental illness" ✓ DO say "a person diagnosed with ..." ✓ DO say "a person having difficulty with thoughts, emotions, relationships and self-compassion."
<ul style="list-style-type: none"> ✗ DON'T emphasize limitations. ✗ DON'T convey an aura of hopelessness when discussing pathology, or discuss pathology in isolation without presenting a related strength or a treatment plan that treats the pathology. ✗ DON'T focus on what is (in your opinion) wrong. 	<ul style="list-style-type: none"> ✓ DO emphasize abilities. ✓ DO focus on what is strong (i.e., the person's strengths, skills, passions, and past successes). ✓ DO offer optimistic but realistic feedback. ✓ DO validate patients' experiences.
<ul style="list-style-type: none"> ✗ DON'T use condescending, patronizing, tokenistic, intimidating, or discriminating language or tone. ✗ DON'T sensationalize a mental illness: <ul style="list-style-type: none"> • This means not using terms such as "afflicted with," "suffers from," or "is a victim of" ✗ DON'T portray successful people with mental illness as superhuman; this assumes that it is rare for people with mental illness to achieve great things. 	<ul style="list-style-type: none"> ✓ DO use language that conveys hope and optimism that supports and promotes a culture that believes that recovery and achieving well-being is possible.

Content adapted with permission from the Mental Health Coordinating Council.²⁷

FACILITATE PATIENT CHOICE AND SHARED DECISION MAKING IN YOUR PRACTICE

Choice and autonomy are important values in recovery-oriented MH&A care. However, constraints of practice can prevent you from offering a range of services or fully engaging and enabling patients as described below. The CFPC, MHCC, and other partner organizations continue to advocate for system reform that would increase access to a range of mental health services and facilitate the provision of patient-centred, continuous care. Even in the absence of a robust system of supports, there are many ways that you can facilitate choice and enable people to make informed decisions.

Co-develop personal care plans with patients (including advance care directives and substitute decision making protocols if appropriate)

Recovery is an individual process, based on the patient's individual needs, situation, and goals. Therefore, individual care plans should be co-developed with patients, and services should be tailored to their unique needs and wishes. Family physicians are already well-versed in providing this type of patient-focused care, as this is a central aspect of the PMH (refer to the CFPC Best Advice guide [Patient-Centred Care in a Patient's Medical Home](#) for more information).

Supporting informed choice by your patient involves providing information about the MH&A treatment options that are available in your community and enabling your patient to make choices according to their condition, preferences, and goals. While there will be limits to what is available in any given community, the range of options spans pharmacological treatments, nutrition, and physical activity, to counselling and psychosocial rehabilitation, as well as peer support programs.

Social determinants of health such as poverty, inadequate housing, and barriers accessing work or education put people at greater risk for developing MH&A issues.²⁸ People with MH&A issues may live in chronic poverty and often face other social and economic barriers.²⁹ When possible, these circumstances should be considered when developing care plans. Refer to the CFPC Best Advice guide [Social Determinants of Health](#) for more information.



Once a personalized care plan is developed in partnership with the patient, research shows that putting it in writing can be very useful. Written care plans are most valuable if they include the following key elements:³⁰

- Setting goals and direction
- Following progress (checking in by self or others)
- Outlining information about where to go to access resources
- Documenting roles and responsibilities of all participants, including the patient
- Discussing opportunities to regain self-mastery (control, hope, and recovery)

The [Wellness Recovery Action Plan \(WRAP\)](#), is a great resource to help patients develop a personalized care plan. Refer to the CFPC Best Advice guide [Chronic Care Management in a Patient's Medical Home](#) for more information and resources (including example personal care plans) for supporting patients with acquiring skills to empower and support self-care.

Case Study - Ajax Harwood Clinic

At the Ajax Harwood Clinic, a PMH in Ontario, patient empowerment is central. As part of personalized treatment care plans, patients can participate in a range of physician-led group sessions including psychotherapy groups, meditation and mindfulness programs, and group appointments for managing chronic conditions. Offering physician-led sessions in your practice is a great way to support your patients in achieving mental and physical wellness. The Ajax Harwood Clinic has [developed a tool kit](#) for physicians implementing self-management groups in family practice.

Advance care directives and substitute decision making

To provide choice and encourage patient involvement in care, you can discuss advance care directives and substitute decision making protocols when it is relevant and/or necessary. According to the MHCC, "... people who live with severe mental health problems and illnesses may be able to maintain more choice and control during crises by preparing advance directives as part of their care plan. These directives express an individual's preferences for services, treatments and supports if he or she should be deemed incapable of making such decisions. They offer an opportunity for people living with severe mental health problems and illnesses, their families, and service providers to discuss issues and build their partnership. They can also help to strike a balance between facilitating families' desire to provide support and respecting the rights of individuals."²⁸ Overall, these tools allow patients with more severe mental health issues to share their care preferences formally with health care providers, families, and caregivers before the patient is no longer able to provide informed consent.

INVOLVE—WHERE APPROPRIATE AND WITH PERMISSION—FAMILIES, FRIENDS, AND COMMUNITY MEMBERS IN CARE PLANS FOR PERSONS LIVING WITH MH&A ISSUES

Family caregivers—including families of choice (friends, neighbours, community members)—play a critical part in caring for and treating patients with MH&A issues. They often serve in a variety of roles, acting as informal case managers, providing crisis intervention supports, acting as a patient advocate and/or substitute decision maker, monitoring and tracking past and current treatments, and much more.³¹ Family caregiver involvement can result in decreased rates of hospitalization and relapse, enhanced engagement with treatments, and increased rates of recovery.³¹

It is important to ask patients about the type and level of involvement they want from their self-identified family caregivers and revisit this topic regularly, as needs evolve over time. Depending on the patient's wishes, you may invite family caregivers to appointments, solicit their feedback as you develop care plans, and ensure they are up to date about relevant developments in the patient's health. Family caregivers are also a great resource given their experience with the patient, so engagement should always be a two-way street.

In addition to involving family caregivers in a patient's treatment, family-focused recovery includes being mindful of and addressing the caregivers' wellness needs as well as those of the patient.³²

Note: This section refers to caring for adult patients. When working with children and youths, regulations and laws for parental/familial involvement will guide decisions about their care.

Resources for families and caregivers

To find out about resources for families or caregivers, such as support groups, contact:

- [Canadian Mental Health Association \(CMHA\) branches](#)
- [Schizophrenia Society of Canada offices](#)
- [Mood Disorders Society of Canada locations](#)
- [Centre for Addiction and Mental Health programs and services](#)
- [Strongest Families Institute](#)

Families and caregivers may also be interested in advance care planning and substitute decision making resources:

- The CFPC [Advance Care Planning Resource for Patients](#)

ENHANCE YOUR CLINICS' OPERATIONS TO BETTER ACCOMMODATE PATIENTS WITH MH&A ISSUES

Make your practice more welcoming and equitable

People who seek help for MH&A issues often report experiencing stigma from various front-line health professionals.³³ In addition, some patients are not aware that their family physician can play a role in providing mental health services. However, given that family physicians provide the majority of mental health services to patients, ensuring practices are accessible to patients is critical. Following are some actions you can take to address potential barriers:

- Consider how your office communicates. This includes everything from access to information (online and in person) and the tone and attitudes of staff, to the language used on materials and the physical set up of your office space.
 - Offer a short anonymous survey to interested patients, to rate these aspects. Then, work with patients and staff to address any issues and implement recommendations. You may consider using Health Quality Ontario's [Primary Care Patient Experience Survey](#) as a starting point, while adding your own questions specifically related to MH&A care.

- Add a sign in your office stating that discussing MH&A issues is part of your role as a physician (e.g., the Canadian Centre for Occupational Health and Safety “[Mental or physical, illness is illness](#)” poster). Persons with lived experience report that small interventions like this make a big difference.
 - In addition to the visual cues, consider introducing a verbal cue at the beginning of each appointment to remind patients that MH&A issues can and should be discussed during appointments. Some people may need time to consider and articulate their reasons for visiting the doctor—allowing this space will make them feel comfortable and more likely to engage positively with medical care in the future.
 - Offer a check-in form or standardized intake form inclusive of questions on MH&A for patients that encourages engagement in the waiting room. The form could ask patients to list the top issues they would like to address, or get information about recent changes in the patient’s life. This tool provides valuable information and may encourage patients to be more open about their MH&A concerns.
 - The [Case-finding Health Assessment \(CHAT\)](#) is a short, validated, and self-administered tool used to identify risk factors for depression, anxiety, anger control, smoking, drinking, other drug use, gambling, exposure to abuse, and physical inactivity.³⁴ Research has demonstrated its efficiency for screening adult patients in primary care waiting rooms.³⁵ You can find the CHAT tool on the *Annals of Family Medicine* website.³⁶
 - Consider providing text message reminders about upcoming appointments for patients who have trouble remembering important information, and/or who experience paranoia or anxiety about answering phone calls.
 - Support your colleagues in changing their learned behaviours to create a stigma-free environment. Challenge stigma and discrimination whenever you see it. (Refer to Appendix C for a list of anti-stigma programs and other training opportunities.)
- For more information about making your practice more accessible to patients with MH&A issues, refer to the CFPC’s [Mental Health Resources](#) guide.

Provide education and training opportunities for yourself and all staff in your practice and ensure training involves people with lived experience

As part of your ongoing commitment to continuing professional development, it is important to engage in learning opportunities to increase your own comfort with, and knowledge of, recovery approaches in MH&A care.

It is important that all members of a practice team have the necessary skills to provide safe and good quality care to individuals experiencing MH&A issues. As the public faces of your practice, administrative staff are particularly important to include. As a starting point, you might ask your office/clerical staff how they feel about working with patients with MH&A issues, and determine if there are any specific skills they need to become more comfortable supporting these patients. Staff should also be trained on confidentiality and sensitivity regarding mental health topics. For example:

- Not questioning patients about what brings them to the clinic in a loud voice at the front desk in front of other patients
- Not reacting negatively when patients return for repeat mental health visits

Research indicates that the inclusion of social contact and personal testimonies from persons with lived experience of mental illness is a key ingredient to reducing stigma.¹¹ Consider seeking training opportunities that involve people with lived experience and their families, or collaborating with patients and families to deliver and evaluate education and training initiatives.

Refer to Appendix C for a list of training programs available in jurisdictions across Canada.

Become familiar with community supports and services, and connect and refer your patients

Some team-based practices have social workers or other MH&A workers who can help with the non-medical aspects of care for individuals experiencing MH&A issues and their caregivers. Specific instances may call for physicians to provide formal or informal referrals to outside services. It helps to have someone in your practice who is aware of the major mental health services providers, peer support services, and other programs in your region to connect and refer patients. Because wait times for specialized services can be significant, providing patients with self-management resources, peer support referrals, personalized care plans, and information for various online/telephone services can support patients as they wait for treatment options. See the Self-Management Resources textbox and Appendix D for more information.

Food banks, employment programs, recreation programs, and community housing agencies may also be resources, depending on patients' specific needs and what is available in their community. If you think your patient might be living near or at the poverty line, consider using the CFPC's [Poverty Tool](#) to identify some resources that can assist with this broader issue. The [CLEAR toolkit](#), developed by the CLEAR Collaborative, is another useful tool for assessing different aspects of patient vulnerability in a contextually appropriate way and easily identify key referral resources in their local area.³⁷

Screening tools

Early identification and intervention of MH&A issues, especially for youths, can help improve outcomes. The website eMentalHealth.ca provides a comprehensive list of screening tools (evidence-based, validated scales) for a range of MH&A issues that may be useful in your practice.

If you need to find MH&A services in your community, try connecting with your local Canadian Mental Health Association office or visiting eMentalhealth.ca. You might develop a handout for your waiting room that includes the contact information for local resources, agencies, helplines, etc. Refer to Appendix D for a list of national MH&A resources.

Where possible and appropriate, address co-occurring MH&A issues and physical health problems by integrating screening, treatments, and supports

It is important to remember that people with chronic physical health problems often face co-occurring MH&A issues. They may also be at greater risk for certain physical illnesses due to side effects from medication or prolonged substance use/abuse. Family physicians play an integral role in providing comprehensive care to patients with chronic conditions through their long-term relationships. In your practice, remain aware of the potential effect of physical and mental disorder comorbidities and screen patients accordingly.

You can routinely include one or two questions about MH&A issues in various appointments with patients.⁴¹ This can help normalize mental and emotional health check-ins in practice and reduce stigma. In situations where more in-depth screening is warranted, you can use specific rating scales and symptom scores such as the [Patient Health Questionnaire \(PHQ-9\)](#) and the [Generalized Anxiety Disorder 7 \(GAD-7\)](#), which are easily accessible and can save you time in assessment and diagnosis.⁴¹

Self-management resources

- Downloadable workbooks:
 - [Positive Coping with Health Conditions: A Self-Care Workbook](#) for adults with medical challenges affecting their mood³⁸
 - [The Antidepressant Skills Workbook for Adults with Depression](#)³⁹
 - [Dealing with Depression: Antidepressant Skills for Teens](#)⁴⁰
- Other web resources
 - [Anxiety BC](#)
 - [Depressionhurts.ca](#)
 - [BounceBack®](#) (delivered by CMHA in Ontario, British Columbia, and Manitoba)

Note on depression screening

It is important to note that screening for depression is not recommended for adults with average risk, according to the [Canadian Task Force on Preventive Health Care](#).⁴²



CONCLUSION

Family physicians in the PMH are well-positioned to provide quality care to patients experiencing MH&A issues within the context of the broader health system. Research suggests that family physicians are the primary providers of mental health care in our system, providing almost two-thirds of all mental health services. Providing this care is a natural extension of their commitment to provide continuous comprehensive care centred on the patient-physician relationship. By adopting recovery-oriented practices, you can ensure that patients experiencing MH&A issues receive the kind of care they need, and better support them in reaching their treatment goals.

At its core, recovery-oriented practice is about fostering a safe, inclusive, non-judgmental culture of hope. Taking a strengths-based approach to care requires you to understand that each journey is personal and occurs within the context of every person's own life experience. That means respecting personal autonomy and preferences, and providing information and advice in a way that is meaningful to people so that they understand and can make informed decisions. Simply having this awareness is the critical first step toward providing recovery-oriented care.

More specifically, by incorporating some of these recommendations into your practice, you can make impactful changes that have the potential to improve the experiences of your patients living with MH&A issues. This guide has outlined some key actions that you can take:

- Use strengths-based language when interacting with patients to foster hope and optimism (refer to Appendix B for information about appropriate language)
- Support patients by co-developing personalized care plans that reflect their comprehensive physical and mental health needs
- Involve patients and, when appropriate, their families, friends, and caregivers in decision making
- Make your practice more accessible using signage, integrating standard intake questions about MH&A issues, and creating welcoming and safe spaces
- Provide training opportunities for yourself and your PMH team, including administrative staff, for supporting patients with mental illness and addiction (refer to Appendix C)
- Become familiar with MH&A resources in your community and build a resource list of agencies and self-management tools for your patients
- Use clinical practice guidelines and screening tools in your care of patients with MH&A issues (refer to Appendix E)

By paying attention to these principles in your PMH, you can better support patients experiencing MH&A issues and demonstrate your commitment to a recovery-oriented philosophy of person-centred care.



Appendix A: Alignment between recovery principles and PMH pillars

The key principles of recovery align with many of the PMH foundational pillars. This means that many family physicians currently practising in a PMH model are already implementing the basis of the recovery-oriented approach to care. For example, providing comprehensive and patient-centred care are key components of both recovery and the PMH. The table below provides a more detailed summary of areas of alignment between the PMH and the recovery approach to help you identify current strengths and opportunities for improvement.

Table 2: Alignment between selected principles of recovery and PMH pillars

PMH Pillar	PMH principles and values	Recovery principles and values
Patient-centred care	A PMH provides care that is focused on the individual patient and tailored to their specific needs.	Recovery-oriented care is an individual process that must involve patient engagement, shared decision making, and treating people within the broader context of their families and communities.
Team-based care	A PMH offers a broad scope of services carried out by teams or networks of providers including each patient's personal family physician.	Recovery-oriented practitioners work through sound partnerships that facilitate access to a variety of treatment options and locally available services and resources.
Timely access	A PMH ensures timely access to appointments within the practice, and advocates for and coordinates timely appointments with other health professionals.	Recovery-oriented practice is patient-centred and should ensure that individuals have timely access to the resources they require.
Comprehensive care	A PMH provides patients with a comprehensive scope of services that meet population and public health needs.	The Mental Health Strategy for Canada calls for the expanded role of primary care in meeting mental health needs, especially because people are more likely to consult a family physician than any other health practitioner for mental health needs.
Continuity of care	A PMH provides continuity of care, relationships, and information for patients.	Recovery-oriented mental health services respond and adapt to a person's age and phase of development.

Adapted with permission from the Mental Health Commission of Canada.⁴³



Appendix B: Recovery Oriented Language Guidelines

The following table contains phrases to avoid, on the left, and alternatives to convey the message in a more positive manner, on the right.

Table 3: Alternatives to stigmatizing language

Stigmatizing language	Language for acceptance, hope, respect, and uniqueness
✗ Kylie is normal	✓ Kylie does not have an illness/disability
✗ Sam is mentally ill ✗ Sam is schizophrenic ✗ Sam is a bipolar ✗ Sam is an anorexic ✗ Sam is ...	✓ Sam lives with/has a mental illness ✓ Sam has schizophrenia ✓ Sam has been diagnosed with bipolar disorder ✓ Sam has experienced anorexia ✓ Sam is a person with/who ...
✗ Kylie is decompensating ✗ Kylie is resistant/non-compliant with her meds ✗ Kylie is ...	✓ Kylie is having a rough time ✓ The traditional treatment hasn't been the right fit for Kylie ✓ Kylie is having difficulty with her recommended medication ✓ Kylie is experiencing ...
✗ Sam is manipulative ✗ Sam has challenging/complex behaviours	✓ Sam is trying really hard to get his needs met ✓ Sam may need to work on more effective ways of getting his needs met
✗ Kylie is non-compliant ✗ Kylie has poor/no insight	✓ Kylie is choosing not to ... ✓ Kylie would rather ... ✓ Kylie is looking for other options
✗ Sam is very compliant/manageable ✗ Sam has insight	✓ Sam is excited about the plan we've developed together ✓ Sam is working hard toward the goals he has set
✗ Kylie is resistant to treatment ✗ Kylie is treatment resistant	✓ Kylie chooses not to ... ✓ Kylie prefers not to ... ✓ Kylie seems unsure about ...
✗ Sam is very difficult ✗ Sam has challenging behaviour ✗ Sam won't engage with services	✓ Sam and I aren't quite on the same page ✓ It is challenging for me to work with Sam
✗ Sam is paranoid ✗ Sam is delusional	✓ Sam is experiencing a lot of fear ✓ Sam is worried that his neighbours want to hurt him
✗ Kylie is manic	✓ Kylie has a lot of energy right now ✓ Kylie hasn't slept in three days
✗ Kylie is dually diagnosed ✗ Kylie has comorbidities ✗ Kylie is MICA/MISA (mentally ill chemically abusing, mentally ill substance abusing) ✗ Kylie is an addict	✓ Kylie is experiencing co-existing mental health and substance use/abuse problems
✗ Kylie has a chronic mental illness ✗ Kylie is chronic ✗ Kylie will never recover	✓ Kylie has been working toward recovery for a long time ✓ Kylie has experienced depression for many years

Adapted with permission from the Mental Health Coordinating Council.²⁷



Appendix C: Mental health and addiction training programs in Canada

The table below provides information about selected mental health and addiction programs that may be relevant to physicians and their practice staff.

Table 4: Mental health and addiction programs

Program name	Organization	Location	Free or cost	Audience focus	English or French
Recovery-Oriented Practice Webinar Series	Mental Health Commission of Canada	Web-based	Free	General	Both
Mental Health in the Workplace	Mood Disorders Association of Ontario	Ontario	Cost	General	English
Combating Stigma for Physicians and Other Health Professionals	Mood Disorders Society of Canada	Web-based	Cost	Physicians/health professionals	English
Understanding Stigma	Centre for Addiction and Mental Health	Web-based	Free	Physicians/health professionals	Both
Project ECHO® Ontario Child and Youth Mental Health (CYMH)	Children's Hospital of Eastern Ontario	Ontario	Free	Physician/NP only	English
Mental Health First Aid	Mental Health Commission of Canada	Web-based	Cost	General	Both
Online Addiction Medicine Diploma	BC Centre on Substance Use	British Columbia	Free	Physician/NP only	English
Applied Suicide Intervention Skills Training (ASIST)	Various	Various	Cost	General	Both
Various offerings related to addiction	Communauté de pratique médicale en dépendance	Quebec	Both	Physicians	French
Practice Support Program's Adult Mental Health (AMH) module	General Practice Services Committee	British Columbia	Free	Physicians	English



Appendix D: Online and telephone MH&A resources

After making a referral to a specialized mental health or addiction program, patients may experience wait times before receiving treatment. In addition to providing information about self-management resources, you may wish to provide patients with the information of some telephone and web-based resources that exist in Canada. These resources may also be useful for patients who are not comfortable accessing in-person treatment.

- [Kid's Help Phone](#)
- [First Nations and Inuit Hope for Wellness Help Line](#)
- [Canadian Mental Health Association \(National\)](#)
- [Mind Your Mind](#)
- [Canadian Association for Suicide Prevention](#)



Appendix E: Clinical practice guidelines

Keep up to date about relevant clinical practice guidelines by visiting the Canadian Medical Association [CPG Infobase: Clinical Practice Guidelines](#). Below are some specific guidelines that may be relevant to your practice, to get you started.

Table 5: Clinical practice guideline resources

Issue	Guideline resource
Alcohol consumption	Collège des Médecins du Québec, Educ alcool. <i>Low-risk drinking guidelines – A guide for physicians and health care professionals</i> . Montréal, QC: Collège des Médecins du Québec; 2012. Available from: www.cmq.org/publications-pdf/p-1-2013-02-01-en-niveaux-consommation-alcool-faible-risque.pdf . Accessed 2018 July.
Anxiety	Katzman MA, Bleau P, Blier P, Chokka P, Kjernisted K, Van Ameringen M, et al. Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders. <i>BMC Psychiatry</i> . 2014;14(Suppl 1):S1.
Bipolar disorder	Yatham LN, Kennedy SH, Parikh SV, Schaffer A, Bond DJ, Frey BN, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. <i>Bipolar Disord</i> . 2018;20(2):97-170. Available from: www.cma.ca/en/Pages/cpg-details.aspx?cpgId=13467&la_id=1 . Accessed 2018 July.
Depression	Series of guidelines from the Canadian Network for Mood and Anxiety Treatments
Schizophrenia	Series of guidelines from the Canadian Schizophrenia Guidelines Working Group
Specific populations	Veltman A, Chaimowitz G. <i>Mental Health Care for People Who Identify as Lesbian, Gay, Bisexual, Transgender, and (or) Queer</i> . Ottawa, ON: Canadian Psychiatric Association; 2014. Available from: www.cpa-apc.org/wp-content/uploads/LGBTQ-2014-55-web-FIN-EN.pdf . Accessed 2018 July.
	BC Reproductive Mental Health Program, Perinatal Services BC. Best Practice Guidelines for Mental Health Disorders in the Perinatal Period. Vancouver, BC: Perinatal Services BC. Available from: www.perinatalervicesbc.ca/Documents/Guidelines-Standards/Maternal/MentalHealthDisordersGuideline.pdf . Accessed 2018 July.
Substance dependence	Bruneau J, Ahamad K, Goyer MÈ, Poulin G, Selby P, Fischer B, et al. Management of opioid use disorders: a national clinical practice guideline. <i>CMAJ</i> . 2018;190(9):E247-E257. Available from: www.cmaj.ca/content/cmaj/190/9/E247.full.pdf . Accessed 2018 July.
	Registered Nurses' Association of Ontario. <i>Engaging Clients Who Use Substances</i> . Toronto, ON: Registered Nurses' Association of Ontario; 2015. Available from: http://rnao.ca/sites/rnao-ca/files/Engaging_Clients_Who_Use_Substances_13_WEB.pdf . Accessed 2018 July.
Suicide	Korczak DJ, Canadian Paediatric Society, Mental Health and Developmental Disabilities Committee. Suicidal ideation and behaviour. <i>Paediatr Child Health</i> . 2015;20(5):257-264. Available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC4472054/pdf/pch-20-257.pdf . Accessed 2018 July.



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